CIRCADIA
by Dr. Pugliese
Advanced Professional Skincare

INFORMED CONSENT FOR SWiCH DERMAL REJUVENATION SYSTEM

Initial on line

1. I, _____, understand that the SWiCH™ Dermal Rejuvenation treatment is intended to improve the condition and appearance of my skin. I understand that the product has been thoroughly studied, clinical trials have been performed on a variety of skin types, and that clinical results may vary according to my own skin type and conditions.

2. I agree to complete a Confidential Skin Health Questionnaire. I agree to complete and be truthful about my physical conditions, pregnancy, medications that I may be taking, and my current skin care regimen. I am also aware that my lifestyle, which if it includes smoking, outdoor exposure, tanning beds, excessive alcohol consumption and/or recreational use of controlled substances, will effect and diminish the effectiveness and result of the SWiCH Dermal Rejuvenation treatment.

3. I am aware that I may experience possible short-term effects of reddening, mild stinging sensations, scabbing, feeling of tightness, and acne-like eruptions in the days following the treatment.

4. I understand there is a possibility of rare side effects, as there is with any product, which has been proven safe and effective in clinical trials. Should I experience an extreme response to this treatment, I have been provided the contact information for immediate response for the remedy.

5. If I have any questions regarding the procedure, I agree to call my skin care professional to discuss any concerns.

6. I understand the cost of the treatment and the fee structure has been explained to me.

7. I understand that I will be provided products by the skin care professional following the treatment, and written instructions for the use of these products have been explained to me. The clinically demonstrated positive results of the SWiCH Dermal Rejuvenation treatment require compliance with the application of these products.

8. I understand that the following conditions preclude me from having this treatment at this time and verify that none of these conditions apply to me at this time.

Initial:

_____ Allergic to aspirin or any salicylic sensitivity
_____ Allergic to citric fruits (oranges, grapefruit, lemons)
_____ History of being "highly allergic" to anything
_____ Pregnant or lactating
_____ Currently use of antibiotics (topical or systemic)
_____ Use of Accutane® within the past 12-months
_____ Laser resurfacing surgery within the last 12-weeks
_____ Using glycolic acid products
_____ Use of Retin-A®, Renova®, retinoids (Vitamin A) in the last 4-weeks
_____ Broken Skin on areas to be treated
_____ Visible inflammation or inflammatory lesions
_____ Recent peels within eight weeks
_____ Herpes virus (cold sores)on mouth
_____ Laser Hair Removal within 6 weeks
_____ Currently undergoing chemotherapy or radiation treatments

INFORMED CONSENT

In the event of any questions or concerns, I will consult my skin care professional immediately. I understand the potential risks and complications and I have chosen to proceed with the treatment after careful consideration of both known and unknown risks, complications, and limitations. I will hold the skin care professional and staff harmless from any liability that may result from this treatment.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Client Signature _____ Date _____

Skin Care Professional _____ Date _____